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# M<sup>edical Education Digest</sup>

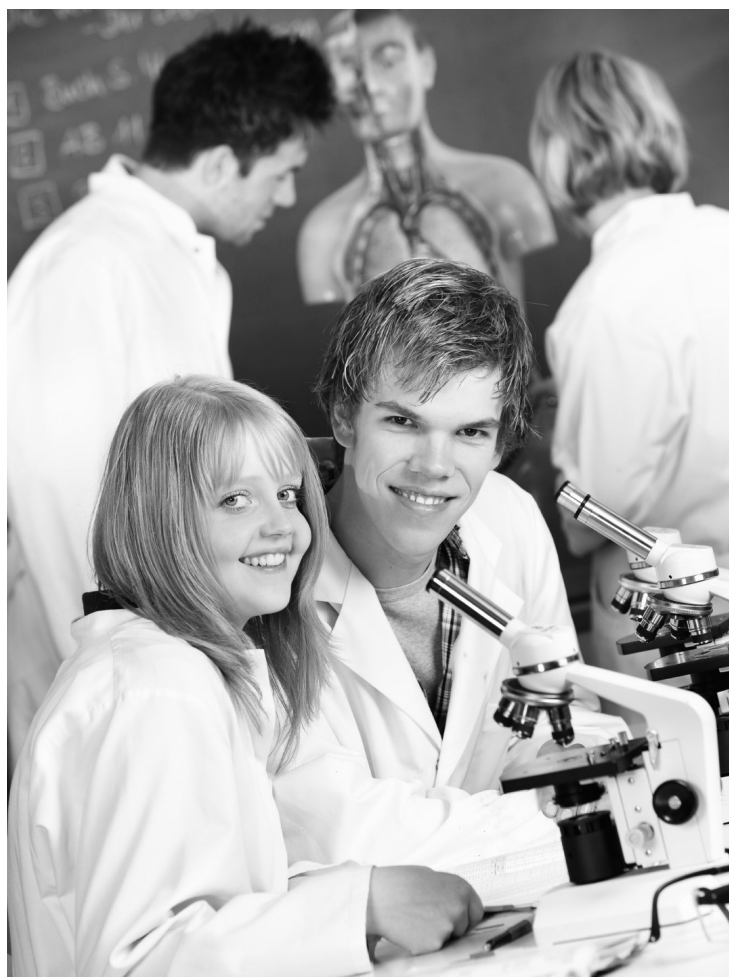


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## Proposals to Shorten Medical School Proliferate



In addition to out-of-control health care costs, there is great waste in the education and training of U.S. physicians, concludes Ezekiel J. Emanuel, M.D., Ph.D., provost of the University of Pennsylvania Perelman School of Medicine, and Victor R. Fuchs, Ph.D., who is affiliated with the Department of Economics at Stanford University.

They indicate that no physician is capable of managing all illnesses, and that a physician can no longer know everything

in his or her own specialty. Opportunities exist to shorten medical education in all of its phases by 30 percent without compromising competence or quality of care. They believe that premedical education can be reduced to two or three years.

Most medical schools in the United Kingdom have six years of education from high school to produce a physician. The University of Pennsylvania has only one year of preclinical science, while Duke University begins its core clerkships in the second year. There is no measureable difference in competence of their students in either of these schools or in performance on boards and residency placement. The authors indicate that the reason for four-year medical school programs was due to the 1910 Flexner Report.

They believe that one half year of preclinical and a year of clinical training could be eliminated without any adverse effects on academic performance. Texas Tech School of Medicine and two Canadian medical schools (University of Calgary and McMaster University) now have three-year programs. In addition, residency and fellowship training can be shortened by at least a year. Some believe that shortening medical training might reduce maturity, life experience, or socialization experiences. However, while physicians would be younger, this does not necessarily mean they will be immature.

Finally, they believe it is wasteful to add years of training to ensure that a small minority of physicians become researchers. Those who wish to become researchers could be provided with additional time to develop their research skills. Ronald Cook, D.O., chair of Texas Tech's Department of Family and Community Medicine, describes a consortium of six medical schools having three-year programs, including Texas Tech, Mercer, Louisiana State University, Indiana University, East Tennessee State University, and the University of Kentucky. Lake Erie College of Osteopathic Medicine also launched a three-year track program in 2007.

*(Emanuel EJ, Fuchs VR. Shortening medical training by 30 percent. Journal of the American Medical Association. 307 (11). 1143-1144;2012. Krupa C. Med school on the fast track. Amednews. American Medical Association. Prl 2057; 05/07/12.)*

*"Medical Education Highlights for Primary Health Care"*

## Rural Residency Training Leading to Rural Practice



The University of Washington Rural Health Research Center reported on the university family medicine residency that combines one year of urban training with two years of rural training (i.e., Rural Training Track-RTT). It has been successful in graduating residents who engage in rural practice to levels as high as 76 percent.

Of the RTT graduates 54.1 percent were male compared to 44.3 percent of family medicine graduates nationally who were men. Allopathic physicians made up 91.8 percent of the graduates compared to 8.2 percent who were osteopathic physicians. Just about half were international graduates. In addition, 72.7 percent of the RTT graduates held certification from the American Board of Family Medicine within two years of graduation, and one out of five was engaged in teaching. About one third of graduates were engaged in practice in Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), or Critical Access Hospitals (CAH).

In addition, the RTT residents are two to three times more likely to practice in rural locations than graduates of family medicine residencies.

*(Patterson DG, Longenecker R, Schmitz R, Xierali IM, Phillips RL, Skillman SM, Doescher MP. Rural residency training for family medicine physicians: graduate early-career outcomes. Policy Brief: Rural Training Track. Rural Health Research Center. <http://www.raconline.org/rtt>; January 2012.)*

## No Kittens in Medical Training



The Physician Committee for Responsible Medicine (PCRM) maintains that intubating kittens can injure or kill them, while the Albert Einstein Medical Center (AEMC) in Philadelphia says that no harm is done to the kittens by pediatric residents who practice endotracheal intubation.

The PCRM is campaigning to end the practice of using animals for research and training. This also includes experimenting with marmosets at Harvard Medical School and pigs in trauma care training at the Baystate Medical Center in Springfield. The PCRM says 192 of the nation's 201 pediatric residencies exclusively employ programmable human-patient simulators in the use of endotracheal intubation.

The group claims that the SimNewB simulator, developed in partnership with the American Academy of Pediatrics, matches neonate anatomy, has the ability to cry, cough, and move its chest. It even turns blue if it does not get enough oxygen. There is no evidence that working with live animals like kittens adds to the training experience, the PCRM claims. It also believes that it is unethical to keep them captive and use them to their detriment. The PCRM also points out that intubated kittens can experience tracheal bruising, bleeding, scarring, airway swelling, and severe pain.

*(Lowes R. Physician group says no to kittens in medical training. [www.medscape.com/viewarticle/764587\\_print](http://www.medscape.com/viewarticle/764587_print); May 25, 2012.)*

## The USMLE and D.O. Student Perceptions

In addition to the Comprehensive Osteopathic Medical Licensing Examination-USA (COMLEX-USA), osteopathic medical students may take the United States Medical Licensing Examination (USMLE). Hasty et al conducted a survey in 19 osteopathic medical schools, acquiring responses from 978 graduating osteopathic medical students to determine their attitudes regarding taking the USMLE.

Students indicated they took the USMLE to be more competitive for certain residency programs. Students in the higher quintiles of their class were more likely to take the examination. Of students who did not take the USMLE, 36.1 percent reported experiencing discrimination. Most graduating osteopathic medical students believed the USMLE should be completed.

*(Hasty RT, Snyder S, Suci GP, Moskow JM. Graduating osteopathic medical students' perceptions and recommendations on the decision to take the United States Medical Licensing Examination. JAOA. 112 (2):83-88; February 2012.)*

# Succeeding in Online Instruction

In the past several years, online instruction for medical education has become quite common. Online teaching offers many rewards for faculty members, but it takes a special set of skills and attitudes to excel at it. However, these are not the same skills and attitudes that make an exceptional classroom teacher. Following are some tips on being a successful online instructor:

## **Don't Expect Constant Validation**

Many faculty members are attracted to the profession by all the ego-stroking they may receive in traditional lecture environments.

## **Work Hard to Know Your Students**

Removing the verbal component of instruction increases the chances of misunderstanding exponentially. It takes a great deal of time and effort on the part of online teachers to be sure they are really clear in their own communications. They need to understand who they are teaching, what students are trying to tell them, and how well their students are succeeding in each course.

## **Accept the Loss of Complete Control**

Fully online instruction can never provide the level of control instructors crave. To a great extent, online education operates on the honor system. You never know who is really doing the work, but students cheat in regular classroom courses, too, while not nearly as easily, and quite possibly, not nearly as frequently.

## **Be Prepared to Work Really Hard**

Online faculty members don't have the luxury of making real-time modifications to their instructional strategies. Their teaching must be accurate and complete. Between preparation, correspondence, and time-consuming troubleshooting of student problems, online teaching may require more effort in teaching technical courses than teaching the same material in person.

## **It's Not Just a Day Job**

Committed online instructors find it hard to set reasonable boundaries on the workday. When students run into trouble, the instinct is to help them as soon as possible since many online students have full-time jobs and seek help at night.

## **Don't Become Isolated**

Online faculty members need to work hard to maintain the kind of peer relationships that on-campus teachers consider normal. Those who provide instruction in person maintain on-campus office hours to serve their students. Online students, on the other hand, may be scattered all over, making it difficult or impossible to keep regular office hours.

(Rose R. 6 keys to engaging students online. *Campus Technology*. pp16-17; June 2012.)

# Careers in Medicine: Workshops for Medical Student Residency Selection

Vanderbilt University School of Medicine created a Careers in Medicine (CiM) program after attending the Association of American Medical Colleges (AAMC) CiM program in 2005. Vanderbilt's program was student run and complimented that of the AAMC by working with interested students to explore the various career tracks available upon graduation from medical school. Residents and faculty members from Vanderbilt interact with medical students without compensation regarding potential career choices.

A series of noon lectures spread across the fall and spring semesters address career selection topics not included in the curriculum. Among these are

*"Building Your CV"*

*"What Residency Programs Want"*

*"Couples in Medicine"*

*"How to Balance Personal and Professional Life"*

*"Academic Medicine vs. Private Practice"*

*"Careers in Business, Government, and Activism"*

Many of the topics are repeated yearly, but suggestions from CiM leadership and students in general may result in changes.

A popular program is called "speed dating" in which medical students in pairs or groups of three rotate through a period of three- to four-minute "dates" with physicians, allowing exposure to a large number of career options in a short period of time. Longer 20-minute sessions with physicians from three specialties are then provided from specialties of their choice. Second-year students also are able to attend a two-hour specialty fair in their spring semester during the time they are considering their third- and fourth-year clerkships.

Booths are set up by different medical center departments with attending physicians, residents, and fourth-year medical students. An elective option available to first- and second-year students called Backstage Pass to the Wards exposes students to a variety of specialties in both academic and private practice through informal, in-class physician panels and shadowing opportunities.

The medical school also produced a Web site (<https://medschool.vanderbilt.edu/cim/>) that provides information about specialties and residencies.

(Sweeney KR, Fritz RA, Rodgers SM. *Careers in medicine at Vanderbilt University School of Medicine: an innovative approach to specialty exploration and selection. Academic Medicine*. 87: 942-948; 2012.)



# Analyzing Disrespectful Behavior by Physicians

A physician's sense of privilege and status can lead to treating nurses, residents, and students with disrespect. Such behavior threatens patient safety as a result of resistance that may occur to following safe practices. A tradition in medical education has been the use of humiliation of medical students and residents. Disruptive behavior by physicians may include inappropriate conduct in words or actions that interferes with or has the potential for interfering with quality health care delivery.

Such behavior may impair the medical team's ability to achieve intended outcomes. Disruptive actions include angry outbursts, verbal threats, shouting, swearing, and the threat or even use of physical force that may be considered battery. Others include temper tantrums, demeaning comments, profane, insulting, or abusive language, throwing objects, sexual harassment, and unwanted physical contact of a sexual nature.

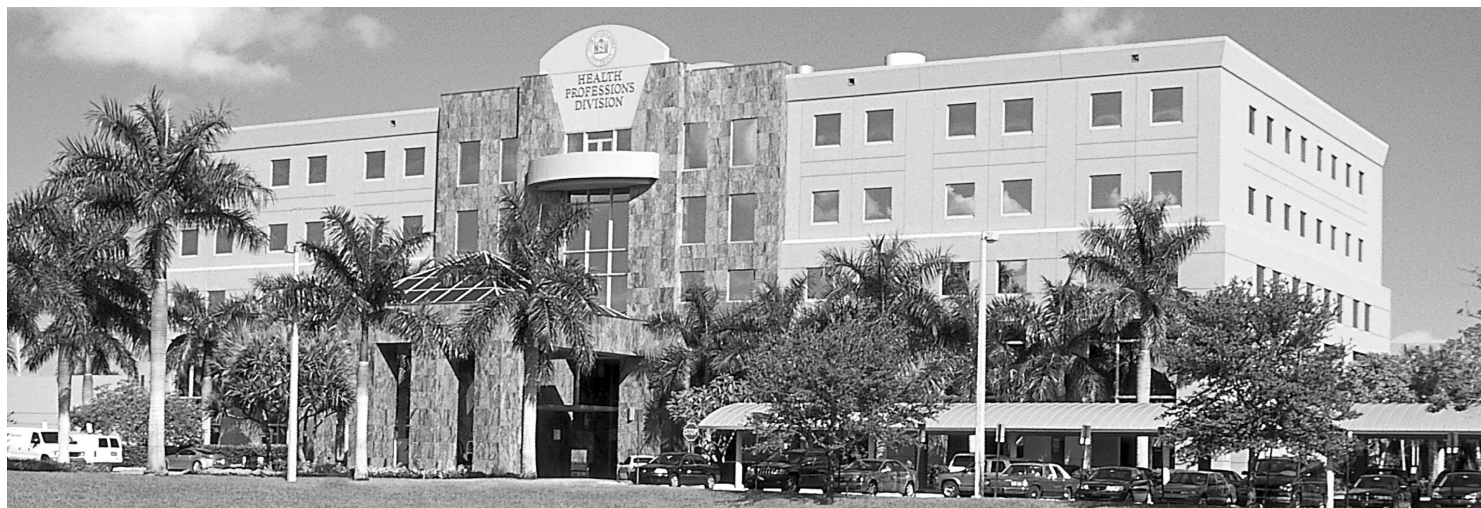
Causes of disrespectful behavior may be endogenous (related to the individual physicians) or exogenous (related to the environment in which they work). Endogenous factors may be associated with threats to self-esteem and be closely linked to the perception of the competence of the physician. It may manifest through insecurity and anxiety stemming from concern about whether the physicians are up to the challenges of practicing medicine, resulting in blaming others when things go wrong or by making demeaning comments. It may also include depression as a result of threats to their personal competence.

Another endogenous factor is narcissism by physicians who have a sense of entitlement to favorable treatment by others and are insensitive to the feelings and needs of other people. Aggressiveness is found in people who enjoy combat and confrontation and who have hair-trigger tempers. In some health care settings, such

behavior is tolerated and even rewarded. An additional endogenous factor is prior victimization in which doctors who were bullied during their formative years reflect their earlier experiences by also being a bully. Exogenous factors are often due to the culture of the institution in which doctors work that may facilitate disrespectful behavior.

Some of society's tolerance for disrespect spills over to health care. Because of the hierarchal nature of the health care culture, disrespect, tied to status, flows down. Medical students, while not outwardly, are typically disrespectful to their professors, or house officers to their attending physicians, often making disrespectful and derogatory comments about their superiors when out of earshot.

*(Leape LL, Shore MF, Dienstag JL, Mayer RJ, Edgman-Levitan S, Meyer GS, Healy GB. A culture of disrespect, part I: the nature and causes of disrespectful behavior by physicians. Academic Medicine. 87:845-852; 2012.)*



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